may limit exercise to avoid symptoms. In many centres, aortic stenosis is still regarded as a contraindication rather than an indication for exercise testing.

In view of the frequency and clinical importance of silent aortic stenosis, we should consider national screening strategies and ways of ensuring that patients with noteworthy murmurs have echocardiography. We need also to develop specialist clinical experience in aortic but also other types of valve disease since diagnostic formulations, treatment plans, and surgery may often be difficult. Aortic valve disease is under-recognised politically as well as clinically. It is not yet covered properly a national strategy document from the National Institute for Clinical Excellence (NICE) or any other organisation. As our population ages, the prevalence of aortic stenosis inevitably rises. By 2020, about 3.5 million of a total population of 54 million in England can be expected to have aortic sclerosis and 150 000 to have severe aortic stenosis.[12] We should prepare for this epidemic now.

John Chambers *consultant cardiologist*

Guy's and St Thomas' Hospitals, London SE1 7EH
(jboydchambers@aol.com)

Competing interests: None declared.

1 Lindroos M, Kupari M, Heikkala J, Tilvis R. Prevalence of aortic valve abnormalities in the elderly: an echocardiographic study of a random population sample. *J Am Coll Cardiol* 1993;21:1220-5.
2 Keogh BE, Kinsman R. *Fifth national adult cardiac surgical database report.* London: Society of Cardiothoracic Surgeons of Great Britain and Ireland, 2003.
3 Connolly HM, Oh JK, Orszulak TA, Osborn SL, Roger VL, Hodge DO, et al. Aortic valve replacement for aortic stenosis with severe left ventricular dysfunction. Prognostic indicators. *Circulation* 1997;95:2395-400.
4 Cosmi JE, Tunick PA, Rosenzweig BP, Freedberg RS, Katz ES. The risk of development of aortic stenosis in patients with 'benign' aortic valve thickening. *Arch Int Med* 2002;162:2345-7.
5 Novaro GM, Tiong IY, Pearce GL, Lauer MS, Sprecher DL, Griffin BP. Effect of hydroxymethylglutaryl coenzyme A reductase inhibitors on the progression of calcific aortic stenosis. *Circulation* 2001;104:2205-9.
6 Cowell SJ, Newby DE, White A, Burton J, Reid J, Northridge DB, et al. Intensive lipid-lowering therapy does not halt the progression of calcific aortic stenosis. *Circulation* 2004 (abstract)
7 Otto CM, Lind BK, Klitzman DW, Gersh BJ, Siscovick DS. Association of aortic valve sclerosis with cardiovascular mortality and morbidity in the elderly. *N Engl J Med* 1999;341:142-7.
8 Cheitlin MD, Alpert JS, Armstrong WF, Aurigemma JP, Beller GA, Bierman FZ, et al. ACC/AHA guidelines for the clinical application of echocardiography: executive summary. *J Am Coll Cardiol* 1997;29:862-79.
9 Das P, Pocock C, Chambers J. The patient with a systolic murmur: severe aortic stenosis may be missed during cardiovascular examination. *Quart J Med* 2000;93:685-8.
10 Horstkotte D, Loogen F. The natural history of aortic valve stenosis. *Eur Heart J* 1988;9(suppl E):57-64.
11 Carabello BA. Aortic stenosis. *N Engl J Med* 2002;346:677-82.
12 Government Actuary's Department. 2003 figures. www.gad.gov.uk/Population/index.asp (accessed 4 Mar 05).

Long term sickness absence

Is caused by common conditions and needs managing

Sickness absence is a major public health and economic problem. In 2003, 176 million working days were lost; up 10 million on the previous year.[1] Each week 1 million people report sick, 3000 of whom will still be away from work at six months.[2] Only 20% of people receiving incapacity benefit for more than six months will return to work in the following five years.[3] The costs are enormous. Each year, £13bn ($25bn; €19bn) are spent on benefits such as incapacity benefit, and the cost to industry is at least £11bn.[4] Long term sickness absence contributes disproportionately to these figures. Although they constitute only a small fraction of absence episodes, longer absences comprise more than a third of total days lost and up to 75% of absence costs.[1 2] Longer absences are associated with a reduced probability of eventual return to work and subsequent economic and social deprivation.

The government is increasingly aware of the issue and has made the reduction of work related ill health and disability, and resulting absence, a top priority.[5] Recently a major overhaul of the incapacity benefit system was announced, in an attempt to remove some of the financial incentives for remaining incapacitated and some early results of vocational rehabilitation programmes have been filtering through. These are primarily aimed at people who have already been in the benefit system for a long time. Moving the agenda further towards primary prevention, the recent white paper, *Choosing Health,* included an important, but somewhat overlooked, chapter on work and health proposing several policy programmes.[4]

What medical conditions are producing such levels of morbidity? It might be expected that only severe illnesses would lead to such marked reduction in function, but in fact most long term absence is due to common conditions that, for whatever reason, fail to improve sufficiently. Until recently the most common causes were musculoskeletal disorders, in particular low back pain. In 1994-5, 194 000 new awards of social security benefits were made for back related incapacities, accounting for more than one in seven such awards.[6] However, since then awards for back conditions have dropped by 42%.[6]

Over the same decade the contribution of psychiatric disorders to sickness absence has increased markedly, and surveys have shown a doubling in the numbers of people reporting stress that was caused or made worse by their work.[7] Mental and behavioural disorders now account for more incapacity benefit claims than musculoskeletal disorders.[3] This has occurred despite no apparent increase, except for alcohol dependence, in their prevalence.[8] In light of this, the Health and Safety Executive has recently produced guidelines on the management of stress at work, based on current understanding of occupational factors such as job strain.[9]

Several recent government initiatives have been introduced to tackle the low employment rates among people with severe mental illness. These include individual placement support, return to work being included within patient care plans, and a strategy against stigma that is based on the social exclusion unit's recommendations.[4] However, it is common men-

BMJ 2005;330:802–3

tal disorders, such as depression and anxiety, rather than complex psychoses, that contribute most to this rising sickness absence. These are managed almost entirely in primary care, where the focus is on patients with apparently greater clinical needs. Effective evidence based treatments are available for these disorders, including antidepressant medication, problem solving, cognitive behaviour therapy, counselling, and collaborative management.[10] Patients tend to prefer psychological therapies,[11] but with a limited capacity to provide them the waiting times are commonly long. Novel approaches to delivery, such as computer based cognitive behaviour therapy, are still at an early stage of development. Both employers and patients require a speedier response than is currently delivered, as the longer an individual remains off work, the more difficult a return to work becomes.

Not uncommonly, a position develops where an individual has recovered sufficiently to consider returning to work but perceives that exposure to his employers, colleagues, or other aspects of work will lead to a relapse. General practitioners can have difficulty linking with employers to effect vocational rehabilitation and, as the patient's advocate, may feel uncomfortable recommending returning to work in this situation. Occupational physicians are best equipped to manage these cases, yet the United Kingdom has very poor provision of occupational health (one specialist for every 43 000 workers) compared with the rest of Europe.[1] A cluster randomised controlled trial in Holland has shown how early psychological interventions for common mental disorders, delivered through the workplace, can enhance health and reduce absence.[12] The intervention consisted of 4-5 sessions of cognitive behaviour therapy to increase activity and coping skills for those off sick for only two weeks. It reduced total sick leave, time taken to return to work, and recurrence at 12 months. If the government is serious about tackling the consequences of common mental disorders then innovative policies, possibly requiring major expansion in occupational health and provision of psychological therapy service in primary care, will be required alongside research into the most effective and cost effective methods of delivering service. This would be a wise investment given the substantial economic and social costs engendered by the current service framework.

Max Henderson *clinical research fellow in liaison psychiatry*

Institute of Psychiatry, Department of Psychological Medicine, Weston Education Centre, London SE5 9RJ
(m.henderson@iop.kcl.ac.uk)

Nicholas Glozier *consultant occupational psychiatrist*

Department of Occupational Health and Safety, King's College Hospital NHS Trust, London SE5 9RS

Kevin Holland Elliott *professor of occupational health and health risk management*

Brunel University, Uxbridge, Middlesex UB8 3PH

Competing interests: NG has received speaking and consulting fees from private and public employers who may benefit from a greater return to work of trained employees. KHE is chair of Corporate Health and Performance, a charity established to research the link between health, productivity and performance at work.

1 Confederation for British Industry. *Room for improvement: Absence and labour turnover (in association with AXA).* London: CBI, 2004.
2 Unum Limited, Institute for Employment Studies. *Towards a better understanding of sickness absence costs.* Dorking: Unum: 2001.
3 Department for Work and Pensions. *Pathways to work: Helping people into employment.* London: Stationery Office, 2002.
4 Department of Health. *Choosing health: making healthier choices easier.* London: DH, 2004.
5 Health and Safety Executive. *Securing health together.* London: HSE, 2000.
6 Waddell G, Aylward M, Sawney P. *Back pain, incapacity for work and social security benefits: an international literature review and analysis.* London: Royal Society of Medicine Press, 2002.
7 Jones J, Huxtable C, Hodgson J, Price M. Self-reported work-related illness in 2001/2002. London: HSE, 2003.
8 Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. *Psychiatric morbidity among adults living in private households.* London: Office for National Statistics, 2000.
9 Health and Safety Executive. Tackling work-related stress. A manager's guide to improving and maintaining employee health and well-being. London: HSE, 2001.
10 Dowrick C. Advances in psychiatric treatment in primary care. *Adv Psychiatric Treat* 2001;7:1-8.
11 Bedi N, Lee A, Harrison G, Chilvers C, Dewey M, Fielding K et al. Assessing effectiveness of treatment of depression in primary care: partially randomised preference trial. *Br J Psychiatry* 2000;177:318.
12 Van der Klink J, Blonk R, Schene A, van Dijk F. Reducing long term sickness absence by an activating intervention in adjustment disorders: a cluster randomised controlled design. *Occup Environ Med* 2003;60:437.

New professional roles in surgery

Would be effective in selected surgical settings and can offer benefits

New professional roles in surgery are a controversial issue. Recent publicity surrounding surgical care practitioners has illustrated the extent of hostility in parts of the surgical community.[1–3] Yet the landscape of the NHS is changing radically. External forces such as the European Working Time Directive are having a profound effect on the United Kingdom's healthcare workforce, and maintaining the current situation is not an option.[4 5]

The unavoidable reality is that we do not have enough doctors to sustain traditional working patterns. Therefore, developing new professional roles seems a logical response. Moreover, role redesign fits with the government's commitment to widen career opportunities in health care and to develop a flexible training structure based on individual competences rather than traditional pigeonholes such as doctor or nurse.[6 7]

Increasing numbers of medically unqualified practitioners are now being trained in surgery related practice, and this is a good time to examine the pros and cons. We write from the perspective of a large university teaching hospital in central London, with a track record of pioneering new roles. Early projects included establishing the United Kingdom's first nurse consultant in coloproctology and a nurse led minor surgery service in west London. Although now widely accepted, these roles aroused great opposition when first introduced.

More recently we have led two national pilot programmes, funded by the Department of Health and

BMJ 2005;330:803–4